Selecting therapies in Benin: making choices between informal, formal, private and public health services

Klein, Thamar

Veröffentlichungsversion / Published Version
Zeitschriftenartikel / journal article

Afrika Spectrum 42 (2007) 3 : 461-481

Thamar Klein

Selecting therapies in Benin: making choices between informal, formal, private and public health services

Summary

This paper addresses a distinctive feature in Benin's health care system. Even though the latest figures state that 83% of the population have access to governmental health facilities, only 36% of the population make use of them. Thus governmental health facilities are extremely under-utilized. Where does this rejecting attitude come from and what kinds of health institutions are used instead? The present study explores this peculiarity and analyses the criteria for therapeutic itineraries in central Benin. A gendered focus shifts the evidence from 'the' Beninese population to gendered perspectives of male and female residents. The findings are based on 22 months of qualitative fieldwork and a large quantitative database obtained from 839 participants in central Benin.

Keywords

Benin, medical anthropology, therapy management, health access

Despite several reforms in the health sector between the late 1980s and the late 1990s due to structural adjustment programmes in Benin and the Bamako Initiative, only 36% of the population reportedly utilise public health facilities (Ministère de la Santé Publique 2002: 20). This is a poor result in the face of enormous health-political efforts and good physical access to health facilities – in 2002 86% of the population had access to functioning governmental health services within 5 km of their homes (Knippenberg et al. 2003: 20). Governmental health care is fee-based, but generally these expenses do not exceed the costs of private care. Charges of informal health practitioners vary to a large extent. The populace is however willing to spend a lot of money in the informal sector (Klein 2005: 267). Public health facilities are evidently relatively accessible in terms of proximity and cost but extremely under-utilized. Apparently consumer needs and preferences are not met by these institutions and so consumers draw on other health care providers. A central objective of this paper is to discuss why the targeted market for governmental health care does not materialise.

Utilising quantitative and qualitative methods while pursuing a gendered user-perspective I analyse the tensions between consumer needs in central Benin and the ability of different informal, formal, public, and private (non-) profit health care services to provide for these needs. I proceed to offer a brief overview of the Beninese health infrastructure, followed by a section detailing the methodology and research sites in central Benin. I then move on to a discussion of the research results in view of the tensions outlined above.

Beninese health infrastructure

In 1999 Benin's health reform measures, which were supposed to improve the quality and accessibility of health care as well as strengthen community participation (approche communautaire), coincided with the decentralization of the territorial government into départements, communes, and arrondissements. Benin's national health system however is only partially congruent with the country's administrative make-up and is based on a pyramidal structure with three layers:

- Central or national level (niveau central/national)
- Intermediate departmental level (niveau intermédiaire/départemental)
- Peripheral level (niveau périphérique).

The peripheral level is not identical with the administrative municipalities (communes), but is divided into health districts or zones (zones sanitaires). These zones sanitaires are the most decentralized units of the Beninese health system and provide for 100.000-200.000 people. From an institutional point of view the health zones consist of a network of public services: village health units (Unité Villageoise de Santé: UVS), health centres of the arrondissements (Centre de Santé d'Arrondissement: CSA), municipal health centres (Centre de Santé Communal: CSC), and the health districts hospital (Hôpital de Zone: HZ) as well as private health services. One of the most important goals of the decentralization process and the resulting establishment of health districts (zones sanitaires) was the integration of the private sector and the improvement of collaboration between private and public health care institutions. The underlying ideal and principle is that primary health care is made available through UVS, CSA, CSC (see above) and private institutions, whereas severe cases are referred through them to the Hôpital de Zone. Another important goal of decentralization was to further community participation (approche communautaire) and the involvement of the arrondissements in health care. This was achieved through the involvement of members of the COGEA (Comité de Gestion d'Arrondissement) in the municipal management committee COGEC (Comité de Gestion Communautaire). The members

of COGEA work together with health professionals to promote health, develop solutions for shortcomings in health care pointed out by the population, develop budget plans, and manage the resources and funding of the health centres. However the powers, organization and operation of these committees are not sufficiently clear and lead to serious conflicts instead of to a closer collaboration between health workers and management committee members (compare e.g. Mbengue et. al. 2000). Thus the COGEA and COGEC lose their important function of enabling the population to address and remedy malfunctions in the governmental health facilities.

Additionally, many patients in my research sites (see Figure 1) were not (sufficiently) aware of the organization of Benin's health system and it's restructuring since 1999, to make use of it in the intended forms. Besides, numerous consumers preferred to go directly to the Hôpital de Zone when they wanted to make use of governmental health facilities instead of going through the great inconvenience of being referred through the different lower level institutions. The Hôpital de Zone however (with its superior equipment and the broader availability of treatments) was often only chosen as a last resort in cases of severe and life threatening illness, as a significant part of the population preferred alternative medical service providers to governmental ones.

Benin offers quite a choice of therapeutic possibilities as health care is shaped by a wealth of therapeutic traditions with converging and diverging philosophies. Globalization has resulted in the availability of a wide array of varied therapeutic services such as TCM (Traditional Chinese Medicine), Biomedicine, indigenous medicines, and various religious healing traditions (e.g. within Christianity, Islam, Ancestor Service and Voodoo). All of these services in their diverse forms and combinations (as profit or non-profit, formal, informal, private or public) are available to a greater or lesser extent in the research area.

Separating these services into a formal and informal or a public and private health sector is a task that is not easy to accomplish. Indigenous health practitioners or so called traditional healers, for example, are often categorized as belonging to the informal sector and biomedical health practitioners as belonging to the formal health sector. However attempts have been made to include or try to include indigenous health practitioners in the state-controlled health sector in many African countries including Benin (for a history on the inclusion of indigenous health practitioners into the formal health sector see Klein 2005). On the other hand many indigenous health practitioners have withdrawn from state control for various reasons (e.g. out of general distrust and fear of exploitation as well as due to the focus on phytotherapy and neglect of religious aspects in healing). Out of 32 indigenous health practitioners – 3 of them religious specialists – in the village Dendougou (one of my research sites) only a single practitioner was licensed. None

of the practitioners saw any advantages in being licensed. Patients chose their practitioners by reputation, which was unattached to the ownership of a certificate. This demonstrates that the term indigenous health practitioner in Benin neither implies automatically an affiliation with the formal nor informal health sector.

The same is true for biomedical practitioners. Public sector health practitioners are known for dual job holding and the receiving of informal payments (Jan et al. 2005). A reasonable number of the well educated also work simultaneously in the formal public and private sector - whereas the not quite as well qualified (e.g. nurses) work additionally in the informal sector, selling for example drugs on the black market. Community health workers (AVS: Agents Villageois de Santé) are equally difficult to categorize. They work in village health units at the lowest level of health service delivery in the Beninese health system pyramid. Their labour is administratively codified but rarely, if at all, controlled.

Many village health units (UVS) have been opened by private religious institutions as well. Formalization of the facilities offered by these institutions therefore varies to a high degree. AVS are not paid for their work and often they are treated as an informal source of drugs:

> 'Là il y a d'autres qui prennent ça [le médicament] à crédit. Il y a les hommes qui prennent ça, même [sans payer]… J'ai même remboursé l'argent de ma poche. Les gens n'ont pas trouvé à me payer. Mais il est malade. Il dit: « Ah, je souffre. Mais voilà que l'argent me manque. » Je dis: « Ce n'est pas grave. Prends. » Maintenant il guéri, il oublie (…). C'est le village qui fait comme ça. Donc, moi je laisse tomber' (Adamou Boukari, 07.04.2004).

A similar entangled situation can be found in Benin's pharmaceutical sector. Unlicensed vendors obtain drugs from informal as well as from state controlled sources.

> 'Il y a un hôpital à Natitingou là, (…). C'est là qu'elles [vendeuses des médicaments] payent les produits là. (…) Oui. Il y a celles qui viennent par le Nigeria aussi. Mais (…) elles ne trouvent pas dans la, bon, dans l'hôpital là [l'Ordre du Malte, Djougou]. On les chasse. Si les blancs les prennent là, on les enferme. (…) c'est à Natitingou que d'autres vont, bon, on les envoie au Nigeria aussi' (Adamou Boukari, 07.04.2004).

This is also confirmed by a survey conducted in 1999 by students of the École des Assistants Sociaux. About 25% of the drugs sold on Cotonou's biggest market Dantokpa stemmed originally from pharmacies, public and private health facilities (Amoussou 1999).

Even though actors in the health sector easily move between the public, private, formal, informal, profit and non-profit sector, true collaboration in the sense of e.g. a contractual approach (approche contractuelle) between private and public health care institutions is practically nonexistent with the

exception of some non-profit establishments in the private humanitarian sector entertaining relationships with facilities in the state sector (compare Ministère de la Santé Publique 2002: 26 f).

Methodology

Research was carried out during three fieldwork periods (October 2000-February 2002, February 2004-June 2004 and November 2005-December 2005) in central Benin. The longest and first fieldwork period was spent in Dendougou, a small village of scarcely 600 inhabitants. Dendougou is used in this paper to discuss health care provided in the rural area northwest of central Benin. Here qualitative and quantitative fieldwork was carried out, in a mixed-methodology design using sequential as well as concurrent triangulation (Creswell et al. 2003).

Besides using unstructured, semi structured and structured interviews, I applied techniques from cognitive anthropology such as free listings and pile sorts to gain knowledge on local medical taxonomies. Participant and direct observation were used, witnessing self-treatment and prophylactic prosaic as well as religious health practices of the population, accompanying patients to public biomedical and indigenous medical specialists or as a patient myself within informal and formal settings. I also carried out some surveys and a long term study monitoring health conditions and therapeutic itineraries. I shall give further details and elaborate on sample sizes in the following sections of this paper.

The data gathered in Dendougou has been contextualized by a statistically representative regional survey undertaken by two colleagues and myself from February 2004-June 2004 for the Department Donga and Borgou on subsistence, well-being and livelihood strategies. This survey covered a surface of 22,260 km² which is about one fifth of Benin's entire territory. In total 839 individuals were interviewed (420 men and 419 women). The data obtained on health behaviour facilitated a statistical analysis on user variables (such as distance, costs, queue time, language spoken by staff/health practitioners etc.) deployed to choose between the magnitude of informal, formal, public, and private health services. It also allowed a statistical analysis of gendered health seeking behaviour.

The final research period in Benin was mainly dedicated to capacity building in form of data transfer of the regional survey and a workshop on the statistical software SPSS.

The regional survey of 2004

The survey covered five major domains: 1) Work, 2) Capital, 3) Health, 4) Risk Management, and 5) Nutrition. In this paper however I shall only draw on some of the results of this survey regarding health.

Most Beninese surveys are based on the household level. Instead we pursued an actor-centred perspective in order to do justice to the complex gender relations and their effects on livelihood and health strategies. Women and men operate profoundly individually and with distinct budgets. Even married couples do not have any insight into each other's budgets (Hadjer 2006: 26, Klein 2005: 143). Spousal pooling of financial resources in health related matters is not the norm and is usually only agreed on in cases where the person responsible for financial support is not able to do so. One of my research results from a survey carried out in Dendougou on the health behaviour of children and youth between the age of 6 and 15 illustrated that even this age group already starts to operate in the informal health sector without their parents' knowledge but with their own individual budget (Klein 2005: 85, 137 f, 196). Analyzing health behaviour on the household level would have blurred the fact that financial responsibility in health care is highly individualized as well as gendered and accordingly affects therapeutic itineraries and decision making.

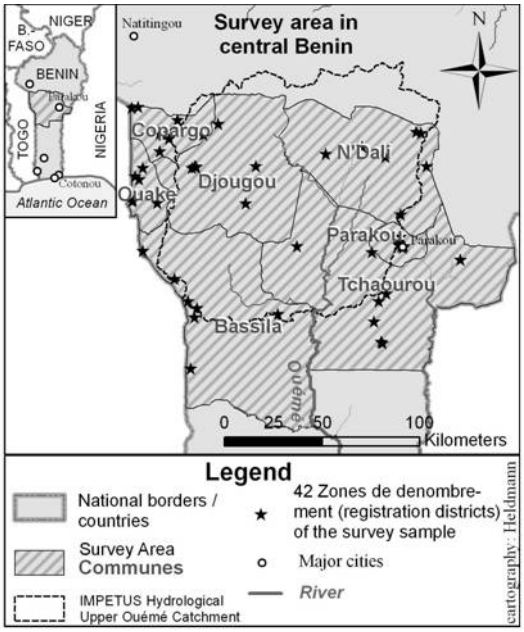
The study was carried out in seven communes of the two départements Donga and Borgou. The research area was originally chosen due to the hydrological borders of the upper Ouémé catchment as the project area of IMPETUS[1], in whose context my research took place. As the hydrological borders do not match administrative borders, those seven municipalities were selected, which shared significant surface portions with the river catchment (see Figure 1). However the research area does not only coincide with the original IMPETUS project area, but is also one of the most poorly supplied areas of public health care in Benin. In contrast to the better resourced south of the country, where the doctor-population ratio is 1: 2,000[2], in central Benin, the ratio is 1: 46,900 and doctors have to care for 23 times more patients (Ministère de la Santé Publique 2002: 24). Thus the extent of utilization of existing public health facilities should be much higher in this region, than in the south. Consequently it represents a good starting point for

1 IMPETUS: Integratives Management-Projekt für einen effizienten und tragfähigen Umgang mit Süßwasser in Westafrika (An integrated approach to the efficient management of scarce water resources in West Africa). For detailed information q.v. http://www. impetus. uni-koeln.de/ impetus.php?show=En_Pr_Ue.

2 In the neighbouring Togo the ratio is 1: 12,500 (PNUD 2005), in Germany it is 1: 300 (OLB 2003: 15).

the investigation of the stated phenomenon of under-utilization of governmental health facilities.

Figure 1: Survey area



The survey sample was based on the population census of the Beninese Institute of Statistics and Economic Analysis (Institut de la Statistique et de l'Analyse Economique: INSAE). Six registration districts (zones de dénombrement) were selected by a simple random sample for each of the seven communes.[3] For every one of the 42 zones de dénombrement we received a map from the INSAE and a sample list of ten randomly selected household[4]

3 The local situation of a very heterogeneous population density was taken into consideration by drawing the sample from registration districts (zones de dénombrement). These are also the basis of the national census as each zone de dénombrement includes approximately the same number of residents.

4 For the purpose of this study, household is defined as a group of people living in the same homestead (or house in the urban sites) and answerable to the same head. Food and income are not necessarily shared. For this reason I also use the term residential unit (RU).

heads. Additionally we received two supplementary lists per zone de dénombrement in case the persons of the primary list could not be located.

The INSAE was only able to draw a sample out of household heads who are in the majority of cases male in Benin. Hence, in order to make women more visible in the survey, we decided, additionally to interview the first (still living) wife of each male household head.[5] In total 839 individuals were interviewed, with 20 people interviewed in each of the 42 registration districts – only one questionnaire went missing due to an error in the application area.

A challenge in the research process was the multitude of languages in the survey area - 35 different languages were spoken in the sample population. Therefore male and female interviewers with different linguistic skills were employed in order to cover at least the eleven most frequently spoken languages. As most of the Beninese are fluent in at least two languages, additional interpreters were rarely needed. The survey questionnaire was translated, pre-tested and revised into the above mentioned eleven languages.

Research site Dendougou

Dendougou village is over 200 years old and situated on an ancient caravan route which once linked Algeria to Ghana. As the people are extremely mobile, Dendougou had a de facto population of 545 persons in 2004 and a de jure population of 625 inhabitants. The population is very heterogeneous, with twelve ethnic groups. The Yowa represent the largest population group with 40%, followed by the Fulbe 18% and the Cocoma 17% (Klein 2004 unpublished census). Most people are Muslim but there are some Christian households as well. Practically everybody performs Ancestor Service and many of the households possess bərra (guardian spirits referred to as 'fetishes' in French).

Dendougou was chosen as the research site after an initial survey in 30 villages of the region on social organization, economy and medicine. It was selected due to a high number of easily reachable informal, formal, private, and public health facilities. In order to examine therapeutic itineraries and criteria for choosing health services it appeared reasonable to choose a site where a broad spectrum of therapy possibilities was available to the citizens. Herbal specialists, diviners, a bone setter, drug sellers, a biomedically trained midwife and indigenous midwives as well as a village health unit (UVS)

5 For male household heads without a wife, the wife of a household head from the supplementary lists was interviewed. We proceeded in a similar way with female headed households.

with an agent villageois de santé who sold basic drugs were available within the village. Moreover, the density of indigenous health practitioners in Dendougou was very high (1 practitioner : 17 inhabitants). Furthermore, Djougou – 10 kilometres from Dendougou and the closest city in its proximity – offered additionally two hospitals (the health district hospital and a faith based private non-profit Maltese hospital), a private physician, pharmacies (including a pharmacy offering TCM) and a wide range of indigenous medical and religious specialists.

Findings

Before I present the data on the population's criteria for choosing specific therapeutic itineraries, I would like to illustrate some findings on decision making and cost management.

Data from initial unstructured and semi structured interviews in Dendougou suggested that male heads of residential units are the decision makers concerning the utilization of health resources and that they also finance the health treatments that are carried out. This was however challenged by more in-depth participant and direct observation which indicated that actually women played an important role in these decisions and spent a lot of their money on their own and family member's health care. I explored these contradictions in a further six months in-depth study on the actual health behaviours of household members in eight residential units. Within this study every person[6] (n = 84) was asked in a three-day interval about their health condition. In case of any reported malaise or indisposition a comprehensive interview was employed to elicit information on symptoms, causation, treatment strategies, financial expenses and decision making procedures. Thus 398 case stories on health itineraries were collected. The analysis of these case stories allowed a more detailed and precise picture: In 70% of all cases women alone had covered the costs and had made the decisions for treatment. But this still did not explain the discrepancies between the stated health behaviour of villagers (male heads of residential units responsible for decision taking and financing) and the observed health behaviour in the long-term study in which women were mainly responsible for decision making and financing.

Thus I followed up the question with a new survey which was applied to every adult in the village (n = 219). I developed a matrix which distinguished local disease categories according to severity and the healing tradition that was said by the interviewed villagers to best cure a specific disease.

6 In the case of infants, their mother was interviewed.

These disease entities were derived from local taxonomies gathered earlier in the research process with techniques from cognitive anthropology like free listings and pile sorts. From this list I selected two diseases that were classified as harmless by the village's indigenous health practitioners (of which one disease was said to be best cured by biomedical specialists and one to be best treated by indigenous health specialists) and two that were classified as severe/potentially life threatening (of which one was said again to be best cared for by biomedical specialists and one to be best cured by indigenous health specialists). A questionnaire was applied to every adult in the village (n = 219) asking, who would make the decision for therapeutic treatment and cover the costs of this treatment if a) an infant, b) a child, c) an unmarried youth, d) a married woman, e) a married man and f) the head of a residential unit were to fall sick with the selected diseases.

One of the results of this survey is that men are regarded as decision makers and financiers of health treatment only in reference to severe (and thus potentially expensive) cases. They were listed however in their roles as fathers and husbands and not in their function as head of residential units (CM: chef de ménage). In fact most of the married men in the researched RUs were not heads of residential units as they lived with their family under the roof of their own father or their older brother. The outcome of the village survey, that in reference to severe cases men but not CMs are decision makers and financiers of health treatment, was confirmed by the regional survey that followed. We were able to collect 238 cases labelled as severe (here defined through the length of sickness: the person had been sick for longer than 7 days) of whom 135 were treated outside the home. In only 12 cases CMs paid for the treatment. Men took over the majority of payments in their function as fathers (50 cases), followed by husbands (16 cases). In 24 cases the sick person paid for the treatment him- or herself (10 of these cases were CMs though). Women paid for the treatment in 14 cases. In the remaining instances the costs were covered by other family members or members of personal networks.

In all of the medical cases regarded as harmless, women were said to decide as mothers for their babies and children, as well as for themselves as unmarried and married women. This was also well reflected in the above mentioned long-term study carried out in Dendougou. All in all, men as fathers spent exactly one third less on health care, than wives as mothers. Thus women occupy a central position in securing the basic needs and the health care of their children when conditions are considered non-life threatening. They earn only small amounts of cash but it is on a continual basis as merchants or manufacturers of goods like soap, oil, or shea butter for example. Rural men's income is seasonal, and they do not make any money during long periods of time and earn a significant amount of money only when selling crops (for a more thorough analysis of gendered rural income see Hadjer

2006: 196 ff). As a result men are often not able to cover health expenses even in the cases where it is expected of them. Women's income varies less seasonally than that of men and is thus available throughout the year. Their budget therefore contributes substantially to health care. Even though El Safty (2001) argues otherwise, the financial role of women and their influence in the decision making processes should not be underestimated.

> 'One other recommended approach that can help in raising the health status of [the] African population is targeting men to increase the use of health services. In a male-dominated society, men have the upper hand. They control household resources; they are the major decision-makers in all family matters, health included.' (El Safty 2001: 13)

Through the triangulation of different methods around the same questions I was able to get a more precise picture with every new exploration; highlighting the importance of a gendered actor-oriented approach.

Evaluation of medical traditions

As has been stated at the beginning of this paper, multiple therapeutic methods and services are available in the village. The most common treatment during the long-term study in Dendougou (n = 398) was self-treatment (67%) with biomedical pharmaceutical products obtained from unlicensed drug sellers (37%) and local herbal drugs gathered in the bush or bought from informal vendors (30%). The village health centre (UVS) and local indigenous health practitioners were both visited in 11% of all incidences, while formal biomedical services were attended in only 5% of the recorded cases.[7] The majority of those 5% however visited private (and) not governmental facilities. No treatment at all was administered (or necessary) in 6% of the conditions. These figures confirm the low utilization of governmental health facilities by the population of Dendougou. A similar trend was reflected in the regional survey (n = 839). Informal drug vendors had for example been used 2.5 times more often than pharmacies. Only 66% of the participants had visited governmental health facilities at least once in their lives but all of them had drawn on medical services from the informal and/or private sector. Why are state controlled public health services only used to such a limited extent? One of the most common complaints of governmental health workers to be

7 The UVS in Dendougou can not be considered as a formal public health facility as it was set up by the religiously run Maltese Hospital in Djougou and serves only as a supplier of pain killers, anti-malaria drugs and anthelmintica. It neither underlies state control nor is it monitored anymore by the Maltese Hospital.

heard in Benin is that people arrive too late in public health facilities. They seem to use it as a last resort only. Again the question arises: Why?

In order to answer these questions, I first analysed the degree of appreciation that people had for specific medical traditions and then to what extent available health services were able to meet users' selection criteria. In the regional survey the different degrees of appreciation were measured in a query that asked the participants to classify biomedicine, indigenous medicines, Chinese Medicine and maraboutism[8] as either 'very important', 'important', or 'not important'. It was possible to rank more than one of the medical traditions in either of the classes. Even though public health facilities are poorly used, biomedicine received the most nominations as a 'very important' medical tradition. In the regional survey (n = 839) biomedicine was classed by 82% as 'very important', whereas indigenous medicines were categorized in this way by only 45% of the male and female interviewees. Chinese Medicine was voted by only 17% to be 'very important' and Maraboutism by 14%.

The high esteem in which biomedicine is held contrasts strikingly with the user frequency of governmental health facilities. Obviously the poor utilization of these facilities does not point to a rejection of this medical tradition per se or a lack of conviction of its effectiveness. This is demonstrated by a brisk demand for – and consumption of – informal sector drugs in the long-term study (n = 398). Pharmaceutical products (both legal and illegal/prescription drugs) were used in 55% of the cases where people referred to self-treatment. Additionally there was a high degree of 'prophylactic' treatment with self-prescribed pharmaceutical drugs e.g. antibiotics and pain killers. These figures do not show in the long-term study, as this survey only covers actual cases of illness. However in another survey that I carried out in Dendougou on all mothers with children younger than 4 years (n = 41), 54% of the children received biomedical drugs on a daily basis. The most frequently used tablets were Paracetamol, Aspirin, Nivaquine, Chloroquine and any kind of yellow pill.[9] The latter had been administered due to their colour and were regarded as fever prophylaxis. This phenomenon was also observed in the regional survey (n = 419 female interviewees). Even though every woman taking part in the regional survey was asked (independent of caring for a child younger than 4), 11% of the women in rural areas and 33% of the women in urban areas confirmed that they were giving their children pills on a regular basis as prophylaxis. The high figure in the cities might be linked to a better access to pharmaceuticals through both informal drug sellers and pharmacies.

---

8 The selection of those four medical traditions was based on their local availability.

9 These drugs were all used as a prophylactic treatment!

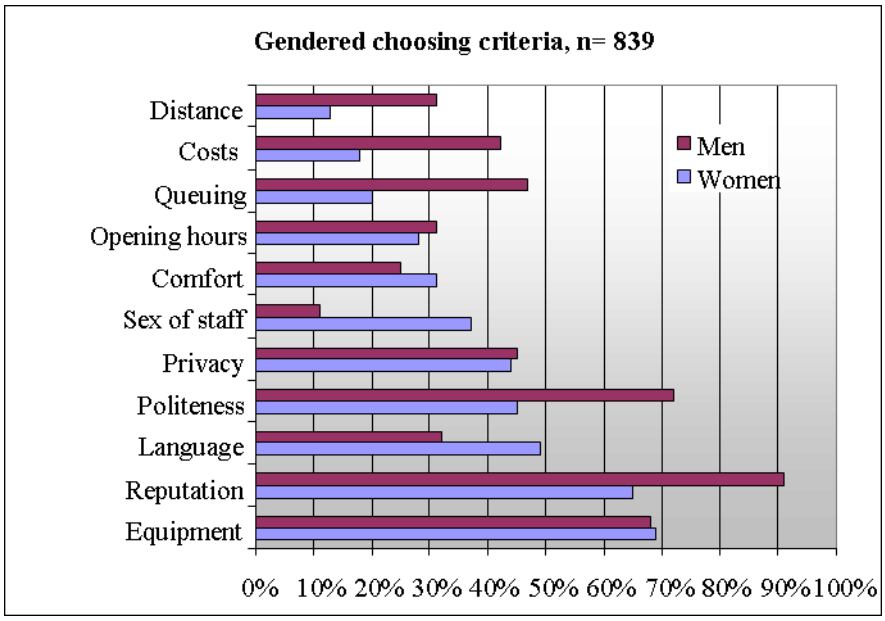
Thus biomedical products are frequently used and the esteem for biomedicine is high but still governmental biomedical facilities are not the first choice of treatment for many. Accordingly there have to be factors unrelated to the esteem for a medical tradition, which bring forth a strong reluctance to use some of its facilities. In the following section these factors will be analysed.

Criteria for choosing therapeutic facilities

The poll criteria for the selection of medical resources in the regional survey were chosen on the basis of my research outcomes in Dendougou. Additionally I have added criteria from two previous studies: a survey conducted in 1979 in Bassila through a country working group of the GDI (German Development Institute) (Lachenmann et al. 1980) and a study conducted by the Department of Tropical Hygiene in cooperation with the Institute for Health Sciences of the University of Abomey-Calavi between 1984 and 1987 (Diesfeld et al. 1988). After the research criteria were developed and selected they were included both in the regional survey and another study in Dendougou. All interviewees had the chance of ranking these criteria as 'very important', 'important', and 'unimportant' to their decision making when choosing a health facility. The queried criteria included the distance between home and the facility's location, queuing time, opening hours, treatment costs, reputation of the institution concerning the treatment available, the facility's equipment, reception (politeness), language spoken by staff/practitioner, privacy, comfort, and sex of staff/practitioner. The following results represent solely the category 'very important' and are differentiated in terms of the sex of the interviewee.

As can be seen in Figure 2 the criteria reputation of the institution, equipment of facility, reception (politeness) received the highest polls.

Figure 2: Gendered choosing criteria



While the reputation and equipment of governmental health facilities were rarely criticized in interviews and discussions, this did not apply to reception (politeness). The staff of governmental health services were generally considered to be impolite and disrespectful and I often observed staff bullying patients or standing around laughing and joking in health facilities in Djougou while seriously injured or sick persons and their family members were waiting to be attended to. That these are no local exceptions can be seen in a series of papers (Audibert et. al. 2004: 16, Badou et al. 2003: 110f, Diesfeld et al. 1988: 56, Hahonou 2002: 60 f, Simshäuser 1995: 123 f, Souley 2001: 22 f).

Hahonou (2002) describes this behaviour as a form of 'control' of the patients through the staff and does not attribute it to bad working conditions of the staff resulting in a low quality of care. Power is exercised over clients through intimidation, disregard, insults, and offensive behaviour to force them into subordination or to abstain from treatment.

> 'Les formes de contrôle sont diverses: mise à distance, infériorisation du patient, menace, insultes, recours à la force physique, déviation des demandes ou exigences des malades, etc. et souvent efficaces. Le revers de cette efficacité qui empruntent différentes modalités pour décourager les patients de sortir de leur rôle attendu, i.e. « être patient », est l'auto-exclusion que l'on constate dans les milieux populaires au pauvres et qui se résume à la formule: « ne va à l'Hôpital que si tu ne peux pas faire autrement! »' (Hahonou 2002 : 67).

The directive above from Hahonou (2002) 'Don't go to the hospital if you still have another choice' was (also) followed by the population of Dendougou. Formal and/or informal private care were preferred to governmental institutions. Due to their high availability e.g. indigenous specialists were considered as an excellent alternative and their respectful behaviour was often pointed out to me. Hospital-based discrimination as described by Lizin (2002) was never reported to me in connection with herbal specialists, bone-setters, diviners, or private doctors for that matter.

> 'Il semblerait que selon que l'on est de telle ou telle ethnie, on paie plus ou moins à l'hôpital; il n'a pas été possible de vérifier cela, mais ces rumeurs accréditent l'idée de l'inégalité ethnique dans les situations d'extrême pauvreté. D'où un danger réel de conflits plus graves qu'il faut absolument apaiser par des règles claires d'accès pour tous aux services de base, surtout dans un pays comme le Bénin où la mobilité est la règle' (Lizin 2002:33).

Besides respect and politeness, more than one third of the interviewees specified privacy, language, and queuing as very important issues in decision making. These issues are addressed more satisfactorily by informal and/or formal private services, for example indigenous specialists in rural settings and micro-unités de Santé in urban regions, than they are by governmental services. Micro-unités de Santé emerged between 1986–1994 in the financially weak urban milieus as a result of the economic liberalization and a reduction of public health sector posts (Dansou 1988, Boidin 1996, Boidin und Savina 1996). These clinics were mainly launched by biomedical staff who could no longer find employment in the public health sector. Private and public clinics were not competitive as the micro-unités de Santé were favourably-priced due to the minimal equipment that had to be maintained. Furthermore, these units offered a more polite reception to users with a custom-tailored service in combination with accessibility. As these facilities are also close to residential areas and the staff/practitioner is personally known, they enjoy a lot of public confidence (Dansou 1988, Boidin 1996, Boidin und Savina 1996).

Most governmental health care institutions that I visited in Benin offered little privacy for clinical interviews and procedures. For instance case histories were discussed in front of strangers and wards were crowded and not segregated according to the sex of patients (compare also Simshäuser 1995: 124). This contrasts strikingly with all the private consultancies I witnessed with indigenous health practitioners (I can not however rule out, that indigenous health practitioners with many patients would not be able to guarantee this kind of privacy).

Language poses a special kind of challenge for governmental health care. Fifty-four languages are spoken in Benin (Ethnologue 2007) and most of the qualified staff originate from the south of the country, where, until very recently, the only university and medical schools were located. Most of the

medical staff therefore are unable to speak any of the local languages and French is not an adequate alternative for the majority of the rural population – especially the women who have received less formal education. There is therefore the need for an interpreter for every such visit to a public health service with all the resulting problems of availability, poor confidentiality and error that this involves. While being hospitalised in Benin myself, I repeatedly witnessed how patients from a neighbouring room were called to translate for somebody in my room.

Informal services such as indigenous health practitioners also perform better with respect to other quality variables such as waiting time. Access problems may occur, however, if the practitioner is not at home and has to be fetched from work.[10] Even practitioners with an excellent reputation and who hence have a considerable amount of patients seem to have no problems attending to their patients in due course. Queuing in governmental facilities is however considerable and often avoidable, too - for instance clients with connections are reportedly seen first and staff apparently often follow private interests (as for example shopping) during working hours. Diesfeld et al. stated that for a mother child consultation of 6-7 minutes there was a waiting time of four hours (Diesfeld et al. 1988: 73).

Correlation of gender and criteria selection

In the following section I shall address the issue of gendered decision making criteria for health service utilization on the basis of the regional survey (n = 839) as there are some highly significant correlations between gender and some of the criteria (with the probability of error below 1%). One of these correlations exists between the sex of the patient and sex of the practitioner ($r = 0.314$; $p = 0.000$). While 37% of all women categorized the sex of a practitioner as very important to them, this was only essential to 11% of the men.

When language was correlated with sex of the patient, a positive correlation was found ($r = 0.176$). As already stated above, women have more communication problems in French than men because of their shorter schooling. Distance ($r = -0.213$; $p = 0.000$), costs ($r = -0.267$; $p=0.000$), reception ($r = -0.277$; $p = 0.000$), and waiting hours ($r = -0.279$; $p = 0.000$) correlated likewise with gender. This time it was the men who stressed the importance of these criteria. In regard to costs this is due to the fact that men are expected to pay potentially costly treatments of severe diseases, as already stated above. The same is true for transportation costs in case of long distances. The higher fe-

10 Most indigenous practitioners do not make a living out of their practice but are e.g. farmers or, in the case of women, merchants.

male acceptance of waiting time and lack of respect is probably related to frustrating experiences in mother-child-consultancies and the result of resignation rather than indifference.

Conclusion

The population of Benin has good physical access to governmental health care: 83% of the populace has a health care facility within 5 kilometres of their residence. Nevertheless, it is informal providers such as drug sellers and practitioners of indigenous medicines as well as formal but private biomedical practitioners who deliver the bulk of medical care. This is, however, not based on disparate aetiologies or contrasting views on reasonable therapeutic behaviour. The aetiologies of the local population and biomedical practitioners are often very similar (for a thorough analysis see Klein 2005). Even where this is not the case, e.g. disorders described as caused by witchcraft, sorcery, ancestors, evil spirits, and gris-gris the symptoms will be treated in addition to the cause. In these cases both forms of healing – prosaic and religious – will be sought. The low utilization of governmental services is not rooted in a negative attitude towards the biomedical tradition. The evaluation of different therapeutic traditions in Dendougou and in the regional survey has clearly demonstrated that the contrary is the case. Biomedicine per se is well regarded. This is also indicated by the tremendous prophylactic consumption of biomedical pharmaceuticals - drugs are popular and their effectiveness is accredited – even though they are not always being used according to formal biomedical regimes.

Neither physical remoteness nor poor availability explain the (preferred) use of mainly informal but also private formal services. In both the regional survey and a study conducted in Dendougou physical distance was the weakest reason and came in last. People are willing to travel long distances for health treatments by e.g. renowned indigenous health practitioners or private hospitals. It appears that the resistance and opposition to governmental health care is to a large extent linked to staff behaviour towards patients (see also Audibert et. al. 2004 and Bichmann et. al. 1991), their language skills, privacy issues and queuing time. While the important criteria of reputation and the equipment of facilities are met by governmental health care, these facilities can not match private formal or informal practitioners in terms of polite reception, privacy, and waiting times.

The above mentioned service quality shortcomings are not specific to biomedicine, but rather deficiencies of governmental health service delivery. This becomes especially visible through the well used biomedical but private micro-unités de Santé in urban regions of southern Benin, which are very much preferred to governmental health care. As mentioned a huge array of

medical services exist alongside the governmental health sector in Benin, including private services, charitable religious health facilities and benevolent NGOs. It is estimated that between 30% and up to 60% of biomedical services are provided outside governmental health care.

The findings of this actor-based approach imply that it is the private care of formal and informal practitioners that meets users' needs best. The efforts to remedy the shortcomings of governmental health care through a stronger involvement of the communities (approche communautaire) has not shown any convincing outcomes yet (compare Audibert et. al. 2004). A similar statement can be made concerning the integration of private health care into the governmental health system. So far collaboration between private and public health care institutions in the sense of a contractual approach (approche contractuelle) is practically nonexistent in Benin with the exception of some non-profit establishments in the private humanitarian sector (compare Ministère de la Santé Publique 2002 : 26f). The possible solutions to outsource health care through an approche contractuelle or to develop private health care in rural central Benin (following the examples of micro-unités de Santé in the cities) resemble and maybe even reflect the patients' behaviour in abandoning hope in the governmental system. The question arises as to what kind of incentives can be given to stimulate institutions and practitioners in the governmental health system to provide for their patients needs to the same extent as the private public and informal practitioners.

References

Audibert, M. et al. (2004): Utilisation des services de santé en Afrique:l'approche communautaire en termes d'offre de soins est-elle une réponse?, online: www.cesh.org/evenement/colloque/2004/Communications_conferenciers/Utilisation%20services%20sant%E9%20Af-rique.pdf>, accessed 26.11.2007.

Amoussou, Joseph M. (1999): *Vente illicite des médicaments au Bénin, cas du marché international de Dantokpa.* Vortrag gehalten am Table Ronde, 14 octobre 1999, Faculté de pharmacie, Paris, online: <http://www.remed.org/fichiers/rapport3.rtf>, accessed 16.04.2005.

Badou, A./Chabi Guiya, F./Hounnahin, R. (2003): *Production sociale de la qualité des soins et l'implication des acteurs dans le processus sanitaire. Hôpital de Zone de Dassa-Zoume.* Cooperation Suisse au Benin. Programme socio Sanitaire (Volet Mediation Sociale).

Bichmann, W. et al. (1991): District health systems: users' preferences for services in Benin. *Health Policy and Planning*; 6 (4): 361-370.

Boidin, B. (1996): Flourishing of Micro-Units of Health Care in Benin. *Cahiers de Sociologie et de Démographie Médicales* 36(4): 357-381.

Boidin, B./Savina, M.-D. (1996): Privatisation des services sociaux et redéfinition du rôle de l'Etat: les prestations éducatives et sanitaires au Bénin. *Revue Tiers Monde* 148, octobre-décembre: 853-874.

Creswell, John W. et al. (2003): Advanced Mixed Method Design. In: Tashakori, Abbas/ Teddlie, Charles (eds.) *Handbook of Mixed Methods in Social and Behavioral Research.* Thousand Oaks: Sage. S. 11-15.

Dansou, F. E. (1988): Le développement des activités informelles dans un contexte d'ajustement structurel. Le cas de la République Populaire du Bénin. In: Lespes, Jean-Louis (ed.) *Les pratiques juridiques, économiques et sociales informelles.* Actes du colloque de Nouakchot, 8-11 décembre. Paris: PUF.

Diesfeld, H.-J. et al. (1988): *Les soins de santé primaires en république populaire du Bénin*. Résultats du projet Bénino-Allemand de Recherche Opérationnelle dans le domaine de la Santé aux Districts ruraux de Banté et de Tori Bossito. Rapport Final. Université National du Bénin et Université de Heidelberg.

Djiwan, H. A. (2000): Des larves pour guérir des blessures ouvertes. In: LE MATINAL 26.07.2000.

El Safty, M. (2001): *Culture, Public Health and Community Development.* Health and Environmental Education Association of Egypt (HEEA).

Ethnologue (2007): online: www.ethnologue.com/show_country.asp?name=BJ> accessed 05.05.2007.

Hadjer, K. (2006): *Geschlecht, Magie und Geld: sozial eingebettete und okkulte Ökonomien in Benin, Westafrika*. Dissertation: Institut für Völkerkunde, Universität zu Köln.

Hahonou, E. (2002): *Les urgences à l'Hôpital National de Niamey*. Etudes et Travaux n° 5. Niamey: Laboratoire d'études et recherches sur les dynamiques sociales et le développement local (LASDEL).

Jan, St. et al. (2005): Dual job holding by public sector health practitioners in highly resource constrained settings: Problem or solution? *Bulletin of the World Health Organization* 83: 771-776.

Knippenberg, R. et al. (2003): *Increasing clients' power to scale up health services for the poor: The Bamako Initiative in West Africa*. Background paper to the World Development Report, online: www-wds.worldbank.org/external/default-/DSContentserver/W3P/IB/2003/10/24/000160016_20031024114304/Rendered/PDF/269540 Bamako0Increasing0clients0power.pdf, accessed 19.05.2007.

Klein, Th. (2005): *Befindensweisen und therapeutische Wege in Dendougou, Benin*. Dissertation: Institut für Völkerkunde, Universität zu Köln.

Lachenmann, G. et al. (1980): *Ansätze zu einer basisorientierten Gesundheitspolitik in Benin: sozio-oekonom. Untersuchung des 'Bereiches Gesundheit' im Rahmen der allgemeinen Entwicklungsanstrengungen im Distrikt Bassila (Provinz Atacora)*. Berlin: Deutsches Institut für Entwicklungspolitik.

Lizin, A.-M. (2002): *Droits économiques, sociaux et culturels: Droits de l'homme et extrême pauvreté. Rapport*. Nations Unies. Conseil Économique et Social, online: www.hri.ca/fortherecord2002/bilan2002/documentation/commission/e-cn4-2002-55.htm, accessed 24.03.2005.

Mbengue, Cheikh S. A./Tingbe-Azalu, A./Omyale, P. (2000): *Health Zones, Co-management, and Decentralization in Benin*. Technical Report No. 52. Bethesda, MD: Partnerships for Health Reform Project, Abt. Associates Inc.

Ministère de la Santé Publique (2002): *Politique et Stratégies de développement du secteur santé 2002-200*, online: www.gouv.bj/en/ministeres/msp/index.php, accessed 11.04.2005.

OLB (2003): online: www.olb.de/downloadarea/beruf/arzt_trends_komplett_1_2003.pdf, accessed 23.04.2005.

PNUD (2005): online: www.tg.undp.org/Socioeco/accessed 23.04.2005.

Simshäuser, U. (1995): *Die Inszenierung von Gesundheit – das Beispiel der Volksrepublik Benin*. Dissertation, Fakultät für Soziologie der Universität Bielefeld.

Souley, A. (2001): *Interactions entre personnels de santé et usagers à Niamey*. Etudes et Travaux n° 2. Niamey: Laboratoire d'études et recherches sur les dynamiques sociales et le développement local (LASDEL).

Zusammenfassung

Der Beitrag befasst sich mit einem spezifischen Phänomen in Benins Gesundheitssystem. Obwohl inzwischen 83% der Bevölkerung Zugang zur staatlichen Gesundheitsversorgung haben, wird diese nur von 36% der Bevölkerung genutzt. Die staatliche Gesundheitsversorgung ist damit deutlich unterfrequentiert. Woraus resultiert diese ablehnende Haltung beziehungsweise die Präferenz für andere medizinische Dienstleister_innen? Die vorliegende Studie untersucht diese Besonderheit und geht den Nutzungskriterien der Bevölkerung Zentral-Benins nach. Durch eine geschlechtsspezifische Sichtweise wird der Fokus von 'der' beninischen Bevölkerung auf die unterschiedlichen Perspektiven von Frauen und Männern gelenkt. Die Ergebnisse dieser Studie basieren auf 22 Monaten qualitativer Feldforschung in Zentral-Benin und einem großen statistisch repräsentativen Regionalsurvey mit 839 Teilnehmerinnen.

Schlüsselworte

Benin, Medizinethnologie, Gesundheitsversorgung

Résumé

L'article porte sur un trait distinctif du système de santé béninois. Malgré que les dernières statistiques indiquent que 83% de la population ont accès aux services de santé gouvernementale, seulement 36% de la population en font usage. Les services de santé gouvernementale sont ainsi extrêmement sous-utilisés. D'ou provient cette attitude de rejet et quels types d'institutions de santé sont plutôt utilisées? La présente étude explore cette particularité et analyse les critères guidant les itinéraires thérapeutiques au Bénin central. Un focus sur le genre fait fluctuer l'évidence de 'la' population béninoise vers des perspectives de résidents hommes et femmes. Les résultats sont basés sur une étude de terrain de 22 mois

et sur une banque de données quantitative substantielle obtenue auprès de 839 participants du Bénin central.

Mots clés

Bénin, anthropologie médical, itinéraires thérapeutiques, accès à la santé

Acknowledgements

This work was supported by the Federal German Ministry of Education and Research (BMBF) under grant No. 01 LW 0301A and by the Ministry of Science and Research (MWF) of the federal state of Northrhine-Westfalia under grant No. 223-21200200. I am especially grateful to Nassirou Bako-Arifari for his support during my research in Benin, and to my colleagues Kerstin Hadjer and Uwe Singer with whom I carried out the regional survey. Special thanks go to Nassirou Bako-Arifari, Martin Doevenspeck and Moritz Heldmann for their significant assistance during the survey. Martin Doevenspeck moreover provided the contacts to the INSAE. Moritz Heldmann monitored the survey, and did the cartography for this paper. Furthermore I am very grateful to the INSAE for their collaboration and all the interpreters who toiled diligently to ensure a successful outcome. Michael Bollig, Hans-Peter Thamm and Ralf Hoffmann contributed to the initial planning of the survey. I would also like to thank Richard Rottenburg, Lindsay Clowes, Julie Laplante, Lauren Muller, Norman Schräpel, Virginie Tallio, and Julia Zenker for their helpful comments on first drafts of this paper as well as the anonymous reviewers for their useful insights and suggestions. Most deeply I am however indebted to the population of Dendougou. My sincerest thanks goes out to you: bən maryo soyo.

Thamar Klein obtained her PhD at the Institute of Social and Cultural Anthropology at the University of Cologne in 2005. Since August 2006 she has been a postdoctoral research fellow in the research group 'Biomedicine in Africa: An Anthropology of Law, Organization, Science and Technology' at Max Planck Institute (MPI) for Social Anthropology in Halle (Germany). Her fields of research and theoretical interest include medical anthropology, gender, queer studies, cognitive methods, social networks and globalisation. Her research work focuses on Africa and includes areas such as Benin, Ethiopia and South Africa.